Department of Health
Child and Adolescent Mental Health Division

Performance Report

Performance Period January 2004-March 2004

Introduction

This report presents third quarter of fiscal year 2004 (January 2004-March 2004) information about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD). It is based on the most current data available. Where possible, data are aggregated at both statewide and district or complex levels.

Data for CAMHD are collected in four major areas: Population, Service, Cost, and Performance Measures. Population information describes the characteristics of the children, youth, and families that are served. Service information is compiled regarding the type and amount of direct care services that are used by children, youth, and families. Cost information is gathered about the financial aspects of services. Performance Measures, including Outcome data, are tracked to understand the quality of services and the performance of operations of the statewide infrastructure needed to provide supports for children, youth, and families. Outcomes are further examined to determine the extent to which services provided lead to improvements in the functioning and satisfaction of children, youth and families.

Selection of Measures

CAMHD continues to report on measures of interest to the Federal Courts regarding the sustainability of improvements made in the children's mental health service system in Hawaii. These measures are:

1) CAMHD outcome and results components will be implemented (Benchmark 22),
2) CAMHD will have developed appropriate CSPs for all children whose care is coordinated by CAMHD (Benchmark 26),
3) Service gap analysis (unserved youth report) will document that no child will wait longer than 30 days for a specified service or appropriate alternative…CAMHD will document in the quality improvement reviews that appropriate referrals are being made (Benchmarks 33 and 54-deemed completed),
4) Personnel and Vacancy Reporting,
5) Benchmarks that describe complex-based service testing, and
6) Complaints (no Benchmark attached, reporting requested by the Felix Monitoring Project).

Pursuant to the Stipulation for Step-down Plan and Termination of the Revised Consent Decree, this report also presents data by Family Guidance Center for numbers of children and youth served by CAMHD, percentage of care coordinator positions filled, and percentage of youth served who have a Coordinated Service Plan.

CAMHD also selects quality measures that align organizational performance with achieving results in core areas of service provision and supporting infrastructure. These measures have served over time to target activities for achieving timely, cost-effective services. Not all indicators link directly to former Court Benchmarks, but rather are measures of an effective system of children's mental health services.

Use of Performance Data in CAMHD

Decision-making and aligning work with improvement objectives

Performance measurement in CAMHD serves a number of purposes. Over time, CAMHD has effectively built internal structures, practices, and reporting systems that use objective data to evaluate the quality and results of services. Implementing these systems has been a slow and steady process, but has served to not only inform continuous improvement efforts at all levels but has provided accountability for organizational performance results. Although accountability practices are not necessarily naturally occurring in organizations, both external pressures and internal leadership has prompted the methodical development of values, conditions and tools for measuring performance.

Key benefits and accomplishments of performance monitoring

Performance monitoring consists of tracking of key performance measures, and using reporting and accountability structures to implement improvement interventions and track change over time.

The key benefits are seen as:

- Communication of values, objectives and overall performance requirements of CAMHD's strategic goals throughout its organization and to its stakeholders,
- Organization of work around these objectives, and
- Informed decisions about services and adjustments to program implementation.

Key accomplishments through CAMHD accountability systems over the past several years include:

- The use of data and a focus on results has become a CAMHD organizational value, and is evident in daily operations at all levels. Performance measure selection and tracking is now in its fourth year of implementation in every unit of CAMHD. This has allowed staff to link their own work processes to strategic outcomes and results.
- Performance measurement also extends to the CAMHD provider network, which systematically track performance data on selected functions.
- Performance reporting about client status, care and service delivery is assessed to determine priorities for improvement, including areas that would benefit from

focused study. CAMHD's internal quality management structure, the Performance Improvement Steering Committee (PISC) and its subcommittees regularly receive performance data and reports regarding the quality and effectiveness of care across the service system. They then develop recommendations for improvements, which are monitored for implementation, and evaluated for impact.

- Enhanced decision support and clinical analysis through the use of "live" data from the Child and Adolescent Mental Health Management Information System (CAMHMIS). Relevant client-related data including functional outcomes, service history, and current interventions are available in profile format ("Dashboards"), which assists Care Coordinators and teams in service planning and review.

- At both the Central CAMHD Office and the Family Guidance Centers (FGCs), Branch Chiefs and supervisors are able to access timely data relevant to unit and staff performance. Local-level managers are also able to monitor regional and statewide trends and performance expectations, which further supports planning and decisions. This has greatly enhanced the Family Guidance Centers to bring timely and accurate data to the table in local-level interagency quality assurance activities.

- The readiness afforded through systematic performance measurement and accountability for improvements created the groundwork for CAMHD to be deemed at 98% compliance with the terms of the Balanced Budget Amendment of 1998, which allows CAMHD to operate as a managed care organization for Medicaid-eligible youth with intensive mental health needs.

- At the recent 17th Annual Research Conference, "A System of Care for Children's Mental Health: Expanding the Research Base," held February 29-March 3, 2004, transformational change called for in the President's New Freedom Commission on Mental Health Report, *Achieving the Promise: Transforming Mental Health Care in America* was discussed. A plenary session address by Dr. Robert Friedman, Director of the University of South Florida's Research and Training Center for Children's Mental Health, and widely known for his seminal work in describing Systems of Care, addressed the need for establishing Performance Management Systems in "From Good to Great for Systems of Care." He cited Hawaii as one of three model systems that has successfully used data-driven performance measurement and evidence-based programs. The conference also featured a workshop by CAMHD and Department of Education presenters entitled "Interagency Accountability Systems Development Within Complex Systems Change in Hawaii."

Data Sources

The primary source for data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through CAMHMIS. CAMHMIS has the ability to produce data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data as earlier described, FGC-specific reports and a host of special reports that aid in performance analysis and decision-making. Additional data

elements used to track Performance Measures are produced by various databases maintained at the State Level.

Several data sets (Ethnicity, Agency Involvement, and Diagnoses) have previously been reported for youth with authorized services versus for youth registered and receiving care coordination through CAMHD. In any given quarter, there are youth who receive case management services as their primary service, or have direct services provided by the Family Guidance Center. In order to present comprehensive data for all youth registered in CAMHD, these data presentations are now presented for youth registered. In most cases, these data have historically closely approximated each other.

Population Characteristics

Population data reflect the third quarter of fiscal year 2004 (January 2004-March 2004) for youth registered in the CAMHD Family Guidance Centers. In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,734 youth across the State, an increase of 72 from the previous reporting quarter (October 2003-December 2003), or a .04% increase in the total population. There has been a slight increase in the population over the past two quarters. CAMHD experienced a significant decline in population in July 2003. Controlling for the youth with Autism Spectrum Disorders and Pervasive Developmental Disorders has not fully explained this decline over time. Assuring access to services for youth with intensive mental health issues is a primary function of CAMHD, and potential barriers to assessment and access are under review. A full discussion of the population trend over the last three years can be found in the Child and Adolescent Mental Health Division Annual Evaluation Report, Fiscal Year 2003. The report can be found on the CAMHD website at http://www.hawaii.gov/doh/camhd/.

The numbers of youth provided care coordination at each of the Family Guidance Centers during the third quarter are displayed below. The numbers for Kauai are for the Mokihana Project in total, which serves youth with both low and high intensity mental health needs.

Table 1. Population of Youth Registered by Family Guidance Center

COFGC	LOFGC	MFGC	WFGC	HOFGC	HFGC	KFGC	FCLB
133	150	168	131	150	390	599	83

The total number of registered youth are described by four subgroups: (*i*) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (*ii*) youth who were in the process of having services arranged (new admissions), (*iii*) youth who received less intensive services through Mokihana on Kauai, and (*iv*) youth who were discharged at some time during the quarter. There was also a percentage of youth who received intensive case management services only. Of the total registered youth, 964 had services that were authorized within the quarter.

Of the registered population (1,734), 150 youth (8.7%) were newly registered in the third quarter of fiscal year 2004. This represents an increase of 24 new admissions from the second quarter. One hundred twenty one (121) youth (7.0%) who had previously received services from CAMHD were reregistered in CAMHMIS, a decrease from last quarter's readmissions of 151 youth. CAMHD discharged a total of 112 youth during the quarter, or 6.5% of the registered population. This is a decrease from last quarter's discharge of 227 youth (13.7% of the registered population).

Of the 964 youth who had services authorized in the quarter, 64 were new admissions (6.6%), 55 repeat admissions (5.7%) and 40 discharges (4.1%). It is important to note that because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size.

The average age of youth registered in the reporting quarter was 14.4 years with a range from 3 to 20 years. As displayed in Table 2, the majority of the youth were male (68%). These demographics have been consistent over time.

Table 2. Gender of CAMHD Youth

Gender	N	% of Available
Females	553	32%
Males	1,181	68%

Table 3 describes the various ethnicities of youth registered in the reporting quarter. In the past, these data were reported for youth with services authorized. Ethnicity data for registered youth have historically very closely approximated data for youth with authorized services. The key difference is that ethnicity data is not available (no data entered) for 32.9% of those registered versus 14.7% for those with services authorized. Those with Mixed ethnicities represented the largest group (30.2%), followed by youth of Hawaiian ethnicity (22.7%). Caucasian made up the third largest ethnic group (19.4%), followed by Filipino (7.9%) and Japanese (4.7%).

Table 3. Ethnicity of Youth

Ethnicity	N	% of Available
African-American	27	2.3%
African, Other	2	0.2%
American Indian	3	0.3%
Asian, Other	10	0.9%
Caucasian, Other	226	19.4%
Chamorro	1	0.1%
Chinese	8	0.7%
Filipino	92	7.9%
Hawaiian	264	22.7%
Hispanic, Other	17	1.5%
Japanese	55	4.7%
Korean	6	0.5%
Micronesian	6	0.5%
Mixed	351	30.2%
Pacific Islander	20	1.7%
Portuguese	32	2.8%
Puerto Rican	13	1.1%
Samoan	30	2.6%
Not Available	571	32.9%

A large percentage of youth who receive case management and direct services through CAMHD are involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 4). In the quarter, 11.1% were involved with DHS, 26.6% had a Family Court hearing during the quarter, and 8.3% were incarcerated at HYCF or detained at the Detention Home. CAMHD continues to receive Federal Medicaid reimbursement to provide behavioral health services within the CAMHD array of services under the

Table 4. Agency Involvement

Agency Involvement	N	%
DHS	192	11.1%
Court	461	26.6%
Incarcerated/Detained	144	8.3%
SEBD	240	13.8%
Quest	569	32.8%

Medicaid state plan for rehabilitative services. A key provision of the Memorandum of Agreement with the Med-QUEST Division allows any QUEST-eligible youth with Serious Emotional and Behavioral Disturbance (SEBD) to receive services through CAMHD. A new category for reporting in this report is the numbers and percentage of the CAMHD population who are determined to be eligible for services through the SEBD referral process. Youth who were eligible for services through determination of SEBD were 13.8% of the registered population. Overall, QUEST-eligible youth who received services in the quarter were 32.8% of the population. Some QUEST-eligible youth may not have been screened through the SEBD process, or are eligible by virtue of their educational or court-ordered status.

Table 5. Diagnostic Distribution of Registered Youth

Any Diagnosis of	N	%
Disruptive Behavior	763	44.0%
Attentional	712	41.1%
Mood	586	33.8%
Miscellaneous	380	21.9%
Anxiety	285	16.4%
Substance-Related	263	15.2%
Adjustment	179	10.3%
Mental Retardation	32	1.8%
Pervasive Developmental	21	1.2%
Multiple Diagnoses	1,184	68.3%
Ave. Number of Diagnoses	2.0	

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

In past reports, diagnostic distribution had been reported for youth with authorized services. In order to convey data for the entire population of youth receiving care coordination from CAMHD, diagnostic information is presented here for all registered youth. Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 5). Thus, the reported percentages may exceed 100% because youth might receive diagnoses in multiple categories. The top three diagnoses of youth with authorized services in the quarter were disruptive behavior disorders (44.0%), attentional disorders (41.1%), and mood disorders (33.8%). This diagnostic breakdown has been fairly consistent over time

Those youth with miscellaneous diagnoses accounted for 21.9% of the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control and eating disorders. Many youth in the population have co-occurring, or more than one diagnosis. In the reporting quarter 68.3% of registered youth had more than one diagnosis, with an average of 2.0 diagnoses per youth (median=2.0).

Youth with substance-related diagnoses represent 15.2% of the population. This statistic may not represent all youth with a substance-related impairment, or the number of youth with substance use identified as a target of intervention. Because diagnostic criteria for substance-related disorders require youth to exhibit a variety of symptoms and impairment, not all youth who use substances or who might benefit from interventions targeting substance use would be diagnosed with a substance-related disorder. Therefore, this statistic is expected to underestimate the total number of youth experiencing a substance-related impairment.

Services

Tracking of utilization of the services within the CAMHD array allows for accurate accounting and data-driven planning and decision-making. Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. On the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (January 2004-March 2004). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

During the quarter, the largest percentages of youth served were authorized to receive services provided in the home and/or community, which consist of Intensive In-home services (44.1%) and Multisystemic Therapy (11.7%). The largest group of youth in an out-of-home setting received services in a Community-based Residential program (18.6%). Youth receiving treatment while in Therapeutic Family Homes accounted for 13.1% of those served, and Therapeutic Group Homes 8.8%.

Table 6. Service Authorization Summary (January 1, 2004-March 31, 2004).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	6	6	0.3%	0.6%
Hospital Residential	21	35	2.0%	3.6%
Community High Risk	10	10	0.6%	1.0%
Community Residential	135	179	10.3%	18.6%
Therapeutic Group Home	68	85	4.9%	8.8%
Therapeutic Family Home	106	126	7.3%	13.1%
Respite Home	0	0	0.0%	0.0%
Intensive Day Stabilization	0	0	0.0%	0.0%
Partial Hospitalization	0	0	0.0%	0.0%
Day Treatment	0	0	0.0%	0.0%
Multisystemic Therapy	78	113	6.5%	11.7%
Intensive In-Home	351	425	24.5%	44.1%
Flex	98	167	9.6%	17.3%
Respite	23	27	1.6%	2.8%
Less Intensive	82	172	9.9%	17.8%
Crisis Stabilization	4	10	0.6%	1.0%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

Utilization of out-of-home services as well as the phenomenon of higher use of the more restrictive level of care, Community-based Residential services has been examined in the

Child and Adolescent Mental Health Division Annual Evaluation Report, Fiscal Year 2003. The Annual Evaluation identified several factors that predicted out of home placement including older age of youth, interagency involvement, disruptive behavior disorders, and youth with substance-related diagnoses. CAMHD is reviewing recommendations for strategies targeted at assuring least-restrictive services. Strategies under review include developing clear guidelines for level of care decision-making, continued focus on CASSP (Child and Adolescent Service System Principles) in supporting parents' role in treatment and care, focus on prevention of out-of-home placements, and more use of evidence-based interventions for youth with conduct issues.

In the reporting period, Flex services were provided for 17.3% of youth served. Flex services are a broad category that range from mental health services not provided through a regular purchase of service contract, to travel for youth in off-island residential programs, to interpretive services. The pattern of relatively few families receiving Respite services continued to have relatively low utilization with only 2.8% of the served population receiving an authorization for this service in the reporting quarter.

Cost

CAMHD uses several sources to produce information regarding expenditures and the cost of services. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the second quarter of fiscal year 2004 (October 1-December 31, 2003). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 7. Out-of home residential treatment services in Hawaii, including hospital-based residential treatment accounted for 83.3% of service expenditures. This compares to out-of home residential treatment services accounting for 82.9% of the total costs in the first quarter of FY 2004, or a .4% increase in percentage of total expenditures. Youth in out-of-state treatment settings accounted for only 1.2% of total expenditures.

Hospital-Based Residential Services experienced a decreased cost of 1.2% in the reporting quarter. Conversely, there was a 2.1% increase in the cost of Community-Based Residential Services. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter had the highest total cost per youth ($43,089 per youth). For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes ($13,147 per youth).

In-Home (Intensive In-Home and MST) and less intensive services accounted for 13.3% of the unduplicated cost of services, which is slightly lower than the last reporting quarter (October 2003-December 2003) percentage of total costs for those categories. Youth receiving Intensive In-Home services at some point during the quarter cost an average of $3,965 per youth ($2,334 for those that Intensive In-Home service only, and no other

services in other levels of care), which continues to be significantly less than the cost per any youth in a residential program. Historically, average Intensive In-Home expenditures per youth have tended to approximate MST averages, while total costs tend to exceed MST total costs due to the larger number of served youth.

Youth who received Flex services during the quarter had a cost of $19,740 per youth, or a cost just in this level of care of $950 per youth. The average cost per youth for a child receiving Flex at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for flex services suggest that youth in out-of home placements account for a high percentage of youth receiving flex services.

Table 7. Cost of Services

Any Receipt of Services	Total Cost ($)	Cost per Youth ($)[a]	Cost per LOC ($)[b]	Cost per LOC per Youth ($)[b]	% of LOC Total ($)[b]
Out-of-State	114,434	19,072	111,579	18,596	1.2%
Hospital Residential	531,274	22,136	395,742	16,489	4.3%
Community High Risk	430,888	43,089	424,710	42,471	4.6%
Community Residential	4,027,334	25,014	3,677,491	22,842	39.6%
Therapeutic Group Home	2,027,348	21,341	1,679,754	17,682	18.1%
Therapeutic Family Home	1,825,327	15,469	1,551,352	13,147	16.7%
Respite Home	4,004	2,002	725	362	0.0%
Intensive Day Stabilization	0	0	0	0	0.0%
Partial Hospitalization	2,046	2,046	2,046	2,046	0.0%
Day Treatment	0	0	0	0	0.0%
Multisystemic Therapy	513,016	4,581	366,774	3,275	4.0%
Intensive In-Home	1,467,154	3,965	863,759	2,334	9.3%
Flex	3,197,829	19,740	153,932	950	1.7%
Respite	134,714	4,989	33,388	1,237	0.4%
Less Intensive	223,581	18,632	13,284	1,107	0.1%
Crisis Stabilization	55,146	6,893	6,830	854	0.1%

Note: [a] Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care. [b] Cost per LOC represents unduplicated cost for services at the specified level

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for central office and Family Guidance Centers that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed analysis is conducted by CAMHD Administrative Services.

Services for Youth With Developmental Disabilities

As reported in January 2004, the Memorandum of Agreement (MOA) between CAMHD and Developmental Disabilities Division (DDD) to continue the provision of services, supports and coordination for youth with mental retardation and/or developmental disabilities was executed in July 2003.

Respite Services

For January, February and March, DDD met respite needs of the target population through the DDD service system. DOH case managers continued with assisting families to access other service options such as DDD Respite (via open enrollment), Home and Community-Based Services – DD/MR (HCBS-DD/MR) waiver program, and other DDD funded supports. The table below shows updated utilization of various DDD services that families accessed to meet their needs.

Table 8. Other Service Options Utilized by CAMHD Respite Recipients

DDD Service	# of Users
*HCBS - DD/MR Waiver	40
**POS - Partnerships in Community Living (PICL)	0
***DDD Respite	55
Family Support Services Program (FSSP)	11

* Waiver admission as of 3/31/04
** There were no PICL referrals for period of 1/1/04 – 3/31/04
* **DDD Respite (CAMHD recipients who applied for DDD Respite in December 2003)

In summary, of the original 205 youth, 132 families (123 from the original list plus 9 "add-ons") or 64% were identified by DDD as eligible and in a position to receive respite supports.

Table 9. Expenditures to Date for CAMHD Respite by Island

Island	# Youth Served	% of Total Youth	Total Cost Per Island	% of Total Dollars Expended	Average Cost Per Youth
Oahu	73	55%	$146,775.18	45%	$2,010.62
Hawaii	34	26%	$89,564.00	28%	$2,634.24
Kauai	11	8%	$54,174.50	17%	$4,924.95
Maui	14	11%	$33,258.00	10%	$2,375.57
Total Youth	132	Total Dollars Expended (July 2002-March 2004)			$323,771.68

While families accessed DDD service options, minimal respite expenditures for the period January, February, and March occurred. The total dollars expended for the target population since July 2002 is $323,771.68.

Residential Services

There are currently ten youth being served under the Individual Community Residential Support (ICRS) contract. To date, all but one out of the ten youth served under the current contract have been admitted to the HCBS DD/MR waiver program. The youth who is not in waiver continues in a hospital-based residential setting.

All ten youth covered under the current ICRS contract continue to live in the same settings. The most recent provider (Child and Family Services) and Case Manager reports indicate consistent school attendance for nine of the youth. Community-based needs of

these nine youth are being met with waiver supports as well as supports from the contract.

The DDD is planning to extend the ICRS contract with Child and Family Service (CFS) because residential supports for three of the youth could not be concretely identified by the targeted timeline of March 2004. The amount of the contract is currently being negotiated. For the one youth in the hospital-based residential setting, because of the need for continued psychiatric treatment services, the DOH case manager is working with the hospital and family to plan for supports after discharge. CAMHD will also be part of community-based supports upon discharge.

Joint Training Initiative

In March 2004, the DDD and CAMHD authored and delivered a one-day training entitled "Sexually Problematic Behavior Across the Lifespan: Clients with Developmental Disabilities in Community Settings." Forty-eight case managers across the Oahu districts attended the training.

Performance Measures

CAMHD uses performance measures to demonstrate sustainability and adequacy of services, results, infrastructure, and key practice initiatives. They measure the ability to maintain gains made since the inception of the Felix Consent Decree, and achieve CAMHD practice standards. CAMHD has set performance goals for each measure. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

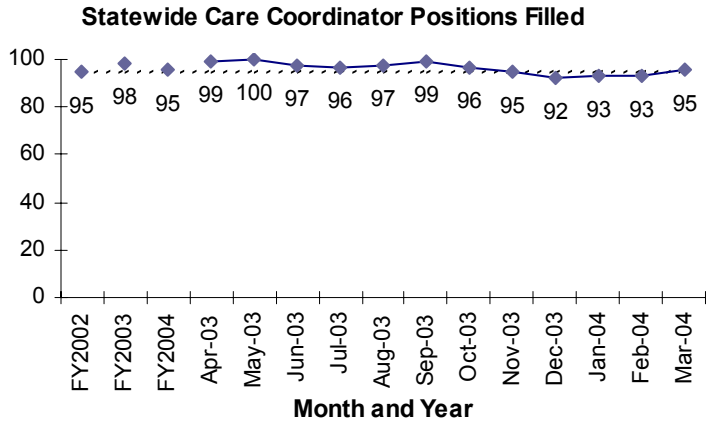
Those performance measures linked to previous Court Benchmarks are noted by an asterisk (*).

CAMHD will maintain sufficient personnel to serve the eligible population

Goal:

⇨ *95% of mental health care coordinator positions are filled**

Over the reporting period, CAMHD had an average of 94% of care coordinator positions statewide filled, which was slightly under the performance goal. The quarter ended with CAMHD meeting the goal. This quarter's data reflects the second consecutive quarter time the performance goal was not met since this indicator was reported at the start of FY 2002. Although the goal was met for the first and last month of the quarter, vacancies in Central Oahu, Maui and the Big Island impacted the Statewide average. The Big Island filled two of their three vacant positions by the end of the quarter, and ended the quarter with 95% of positions filled.



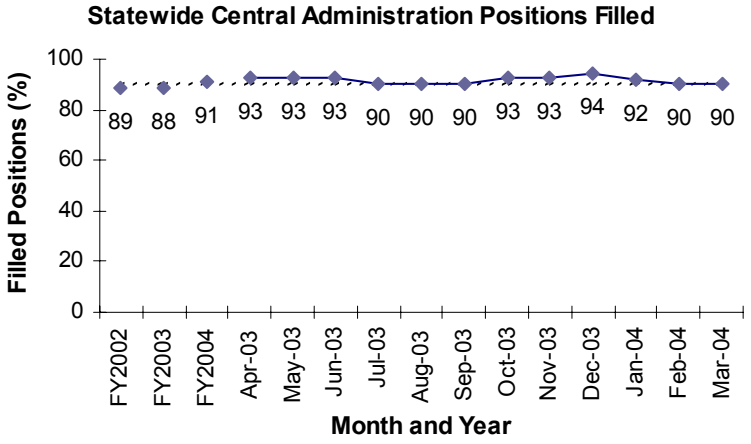
The percentage of filled Care Coordinator positions over the quarter for each Family Guidance Center is displayed below.

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KAUAI
88%	100%	95%	100%	100%	85%	100%

Goal:

⇨ *90% of central administration positions are filled**

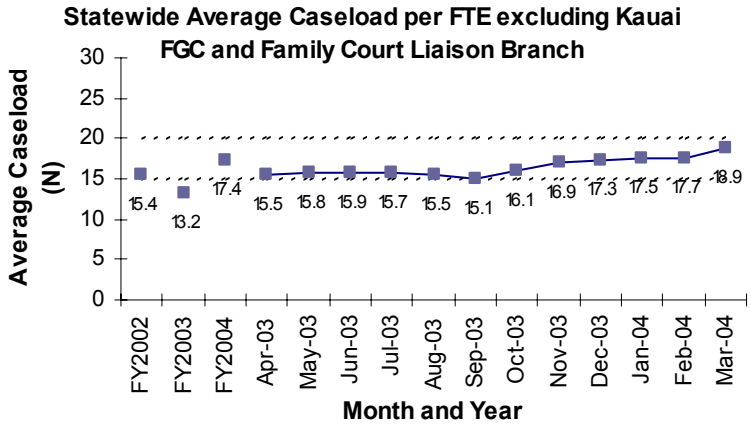
The performance target was met with an average of 91% of central administration positions filled over the quarter. Central Administration positions provide the infrastructure and quality management functions necessary to manage the statewide service system. This quarter's data was slightly below last quarter's performance, and was impacted by several vacancies across the sections, which are all under active recruitment.



Goal:

⇨ *Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.*

The average caseload for the third quarter was within the target range at 18.0 youth per full time care coordinator equivalent (FTE). CAMHD expects that care coordinator caseloads fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services.



The average caseloads performance target was met for three of the FGCs. It was not met for Maui FGC, Honolulu FGC and Hawaii FGC. Vacancies impacted the average for the Big Island, while Maui continues to provide coverage for rural areas (Lanai, Hana and Molokai), which impacts their average. Honolulu Family Guidance Center does not have Care Coordinator vacancies, however, population fluctuations in the Honolulu District have impacted the average caseloads in this area over time.

Average Caseloads by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
3rd Quarter Average	18	17	21	17	14	21

The calculation of average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads. Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center.

CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight

Goal:

⇨ Sustain within quarterly budget allocation.

The reporting quarter for this performance measure is October - December 2003 in order to allow for closing of the contracted agency billing cycle. The total variance from the budget for the second quarter was under projection by $4,200,000. These projections include service dollars that have been or will be encumbered and/or expended in the remainder of the fiscal year. CAMHD continues its trend of sustaining below the budget allocation in the quarter. Central Office expenditures were below budget. Family Guidance Centers' expenditures were higher than budgeted. Service expenditures accounted for 89% of the variance. Rate changes for contracted provider services made in March 2004 have had a significant impact on expenditures. More recent projections of fiscal expenditures have been done with data through March 20, 2004. The resulting analysis shows the expenditures much closer to the allocation.

Variance from Budget (in $1,000's)

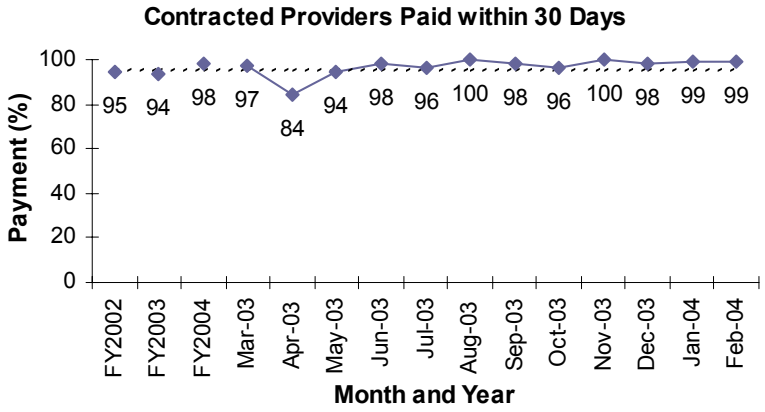
	FY 2002 Average	FY 2003 Average	FY 2004 Average	2003.1	2003.2	2003.3	2003.4	2004.1	2004.2
Branch Total	$164	-$150	$98	$66	-$195	-$312	-$162	$134	$62
Services Total	$798	-$4,175	-$1,952	$315	$2	-$16,251	-$5,941	$59	-$3,963
Central Office Total	-$189	-$388	-$262	-$833	-$216	-$352	-$151	-$226	-$298
Grand Total	$773	-$4,713	-$2,116	-$452	-$408	-$16,915	-$6,254	-$33	-$4,200

CAMHD will maintain timely payment to provider agencies

Goal:

⇨ *95% of contracted providers are paid within 30 days*

The target goal was met for the quarter with 99% of contracted providers paid within the 30-day target. This was a slight improvement over last quarter's result of 98% paid within 30 days. As standard for reporting, data is only available for the months of January and February, as March's payments are still in mid-cycle.

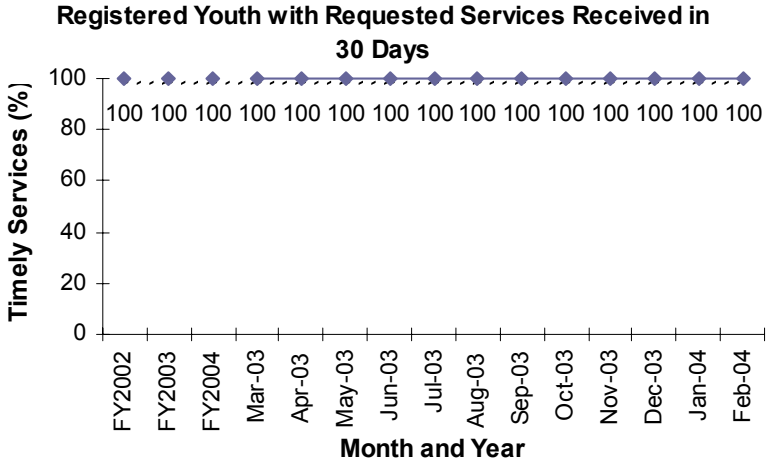


CAMHD will provide timely access to a full array of community-based services

Goal:

⇨ 98% of youth receive services within thirty days of request*

The goal was met for the quarter with 100% of youth provided timely access to services. The last reported service gap was in August of 2001. As usually reported, this data are only available for the first two months of the quarter, and the last month's data will be reported in next quarter's report.



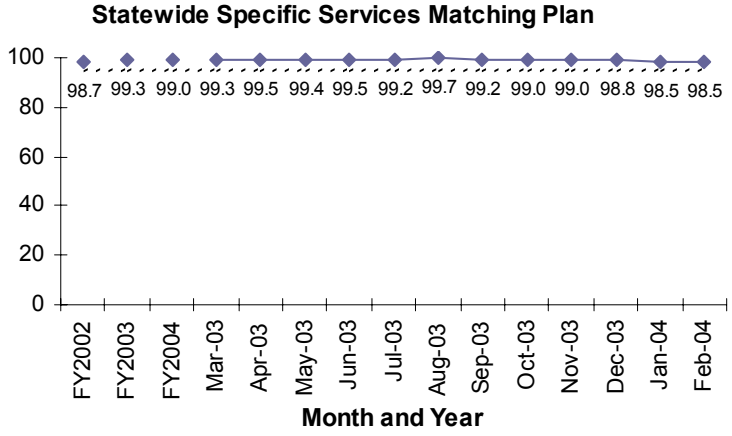
Goal:

⇨ 95% of youth receive the specific services identified by the educational team plan*

CAMHD continued to demonstrate strong performance on this measure. Over the quarter 98.6% of youth received the specific

services identified by their team plan. These youth received services within 30 days, but they were not the exact service prescribed by their IEP teams. As usually reported, these data are for the first and second month of the reporting quarter as third month data are not available at time for publication.

In the third quarter, service mismatches occurred in eighteen complexes versus ten complexes in the previous quarter. Hilo and Keaau had 6 and 5 mismatches respectively. Issues related to court involvement and transition of MST services to a new provider agency impacted youth receiving the exact service in their IEP within 30 days for these complexes.



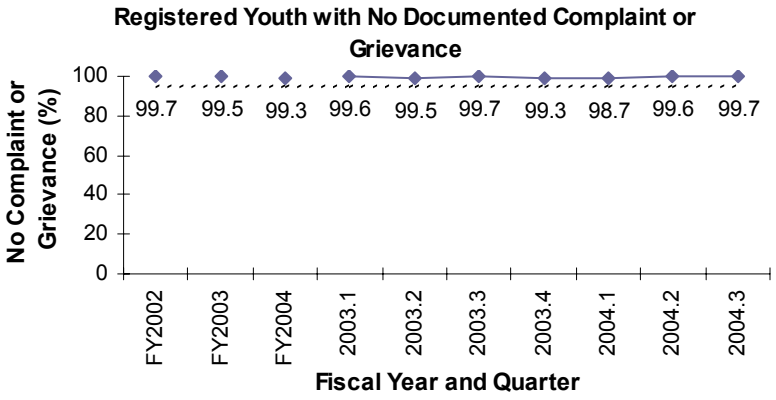
Waianae complex had three (3) mismatches, and the remainder of the complexes experiencing mismatches had two or less. Baldwin Complex, which had struggled over the past three quarters, had only two mismatches in this quarter. This data will be tracked to assure sufficient intensive in-home capacity on Maui to serve youth in the Baldwin Complex.

CAMHD will timely and effectively respond to stakeholders' concerns

Goal:

⇨ 95% of youth served have no documented complaint received*

99.7% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers.

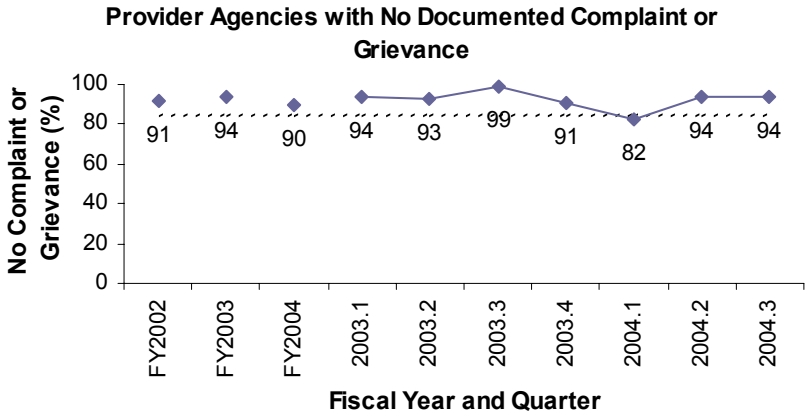


In the quarter, there were 5 youth with documented complaints representing 4 complexes statewide. This compares to 9 youth with documented complaints representing 9 complexes last quarter, and 22 youth representing thirteen complexes in the first quarter of fiscal year 2004. Radford, Kailua and Molokai each had one grievance, and King Kekaulike had two.

Goal:

⇨ 85% of provider agencies have no documented complaint received

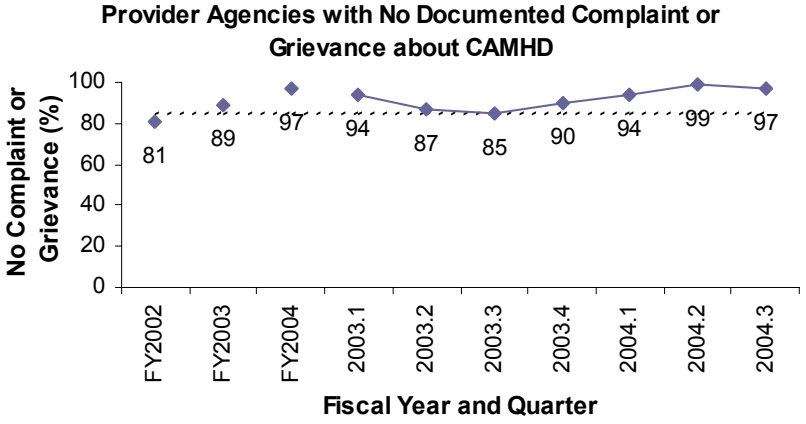
94% of provider agencies had no documented complaint about their services meeting the performance goal. There has been stable performance over the last two quarters.



Goal:

⇨ 85% of provider agencies will have no documented complaint about CAMHD performance*

In the quarter, 97% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which met the goal for this measure. This measure has consistently met the performance goal since the beginning of FY2003.

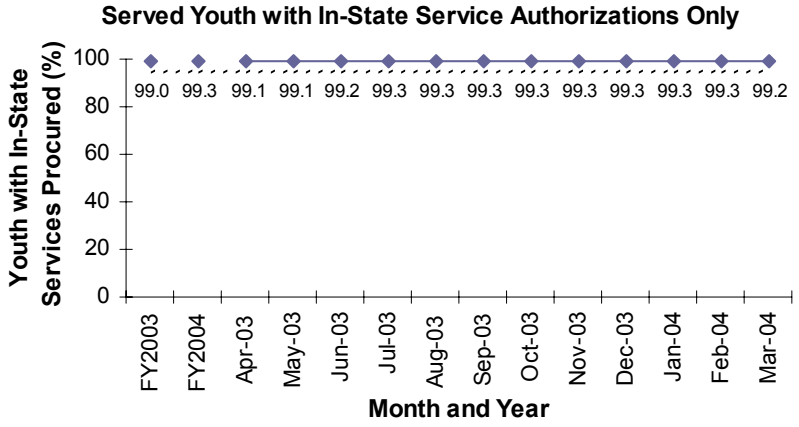


Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting

Goal:

⇨ 95% of youth receive treatment within the State of Hawaii*

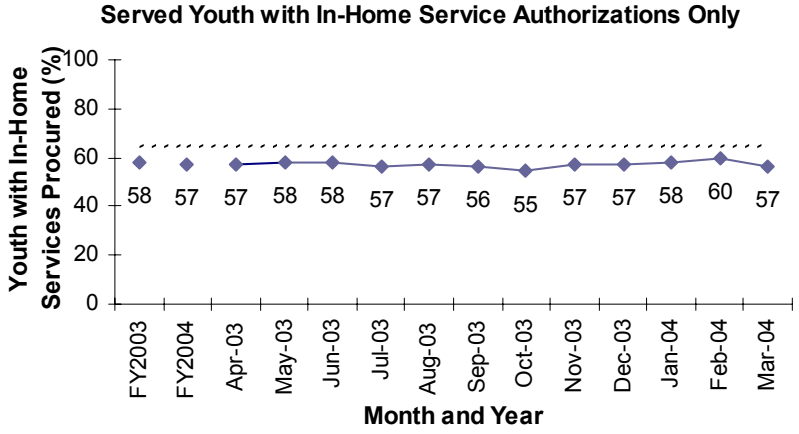
In the quarter, an average of 99.3% of CAMHD registered youth served received treatment within the State, which exceeds the goal. Six youth received services in out-of state treatment settings in the quarter, which is one more than in the previous three quarters.



Goal:

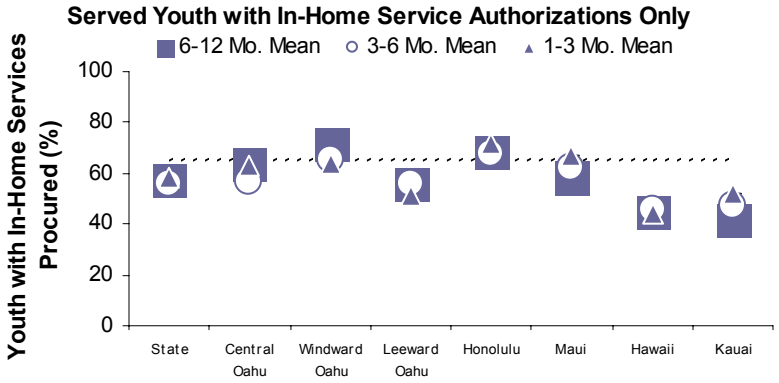
⇨ 65% of youth are able to receive treatment while living in their home

The quarter's data showed that an average of 58% of youth were served in their home communities throughout the quarter, which was short of the performance goal of 65%, and below the performance of last quarter.



The performance goal reflects the historical service utilization patterns of youth with intensive needs. The baseline trend for youth receiving services while living in their homes averaged 58% of the CAMHD population throughout FY 2003, and is averaging at 57% for FY 2004. As seen below, there continues to be variable performance across the

Family Guidance Centers, however, this quarter represents the largest number of Family Guidance Centers achieving or nearly achieving the goal. The goal was met for Honolulu FGC (72% served in their homes) and Maui FGC (67% served in-home), and nearly met for Windward FGC (64% served in-home).



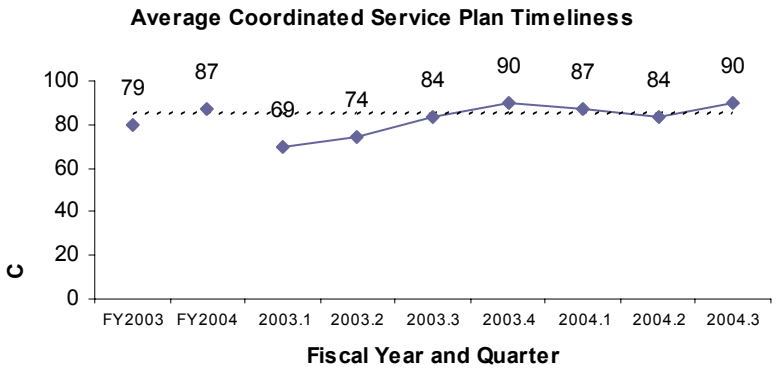
CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

⇨ 85% of youth have a current Coordinated Service Plan (CSP)*

CAMHD's performance in this measure met the performance goal for the reporting quarter with 90% of youth across the state having a current CSP.

"Current" is defined as having been established or reviewed with the CSP team within the past six months. Quarterly reviews of timeliness are conducted to assess for current CSPs. The expectation that any newly registered youth will receive an initial Coordinated Service Plan within 30 days of enrollment remains.

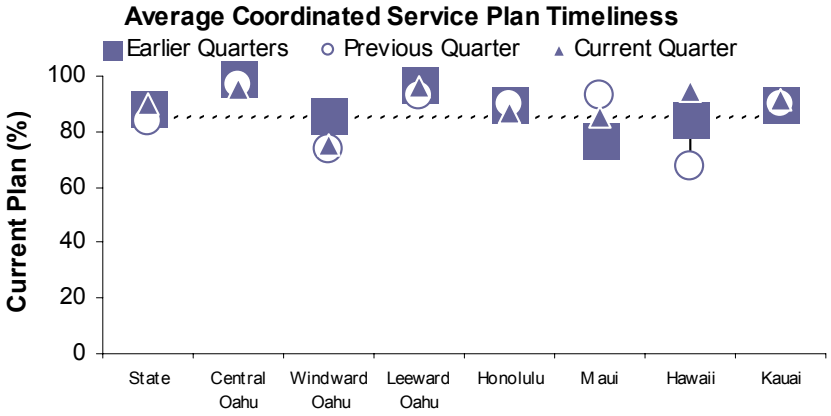


Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed.

Average CSP Timeliness by Family Guidance Center

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KFGC
95	96	85	75	87	94	92

As seen above, the timeliness goal was met for all of the Family Guidance Centers with the exception Windward Oahu. Windward Oahu has struggled in meeting the performance goal over the past two quarters. The most noticeable improvements have been seen on the Big Island, which implemented focused efforts over the quarter to implement strategies to increase timeliness of CSPs for the Hawaii FGC included intensive support to the Mental Health Supervisors from the Branch Chief; action plans to prioritize projects for areas that are short-staffed, and moving to fill vacancies. Windward FGC had identified barriers last quarter, which appear to continue to affect the timeliness of their plans. WOFGC had noted a tendency for staff to schedule CSP reviews late in the quarter versus staggering the schedule over time. Stronger supervision and accountability for improvement strategies will be implemented over the next quarter to assure stronger performance. Trend information for timeliness of CSPs for each of the Family Guidance Centers is displayed below.

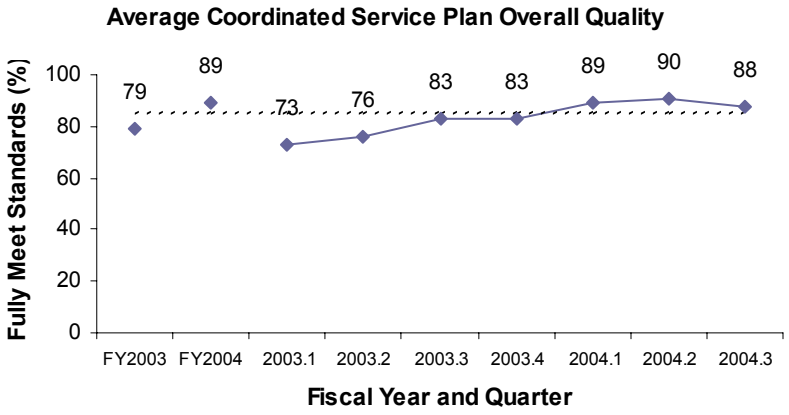


Goal:

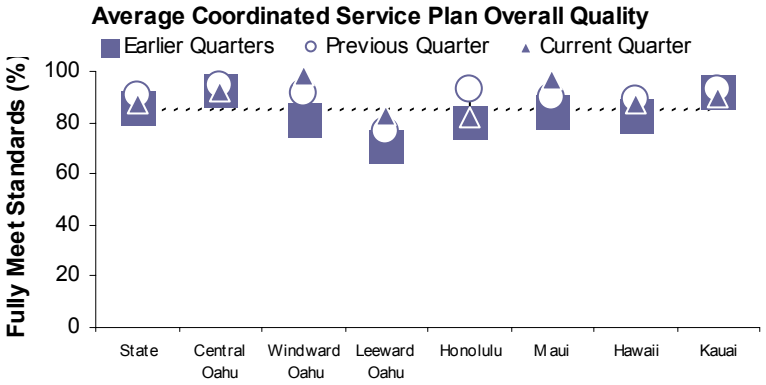
⇨ 85% of Coordinated Service Plan review indicators meet quality standards*

The goal for this measure was met in the reporting quarter with 88% of CSPs sampled meeting overall standards for quality. Quarterly reviews of CSPs against quality standards are a part of the systematic monitoring within each FGC. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, a clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and other key measures.

The statewide data for quality of CSPs are displayed below:



The goal was met or exceeded by all FGCs with the exception of Leeward and Honolulu FGCs. Leeward's CSP quality has an improving trend, but data indicate a continued need for improved CSP quality. These issues have been forwarded to the CAMHD Practice Development Section and Leeward and Honolulu FGCs' Quality Assurance Committees.



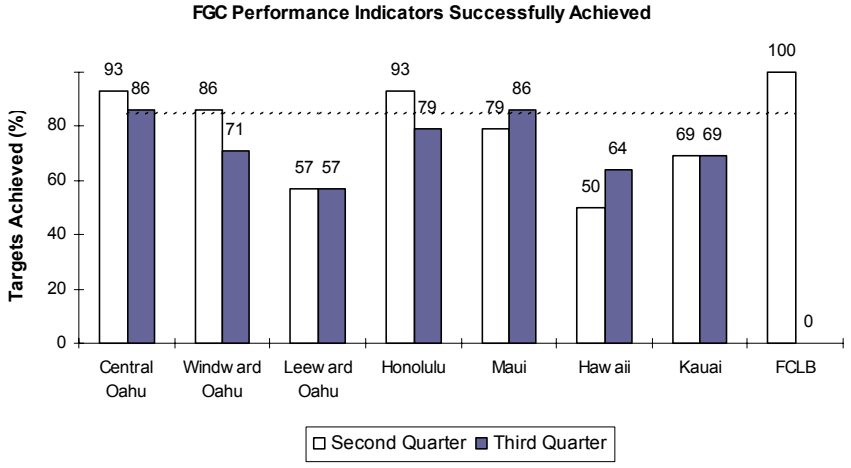
Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ 85% of performance indicators are met for each Family Guidance Center

Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: expenditures within budget, grievances, access to services (service gaps/mismatches, least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, and improvements in child status.

The goal of meeting 85% of the performance indicators was met by Central Oahu and Maui FGCs. In comparison to the two previous quarters, this quarter's performance goals were met by only two FGCs. On average across all FGCs, 64% of all goals were met in the quarter, compared to 78% in the last quarter, and 55% in the first quarter of FY 2003. The Family Guidance Centers generally did well in indicators of timely access, response to concerns, serving youth in the State, and youth showing improvements as measured by the CAFAS or ASEBA. The FGCs that did not meet the goal for performance this quarter tended to struggle with expenditures within their budgets, serving youth in their homes, impacting acceptable child status as measured by the Internal Reviews, completing CAFAS and ASEBA measurement, and family satisfaction.

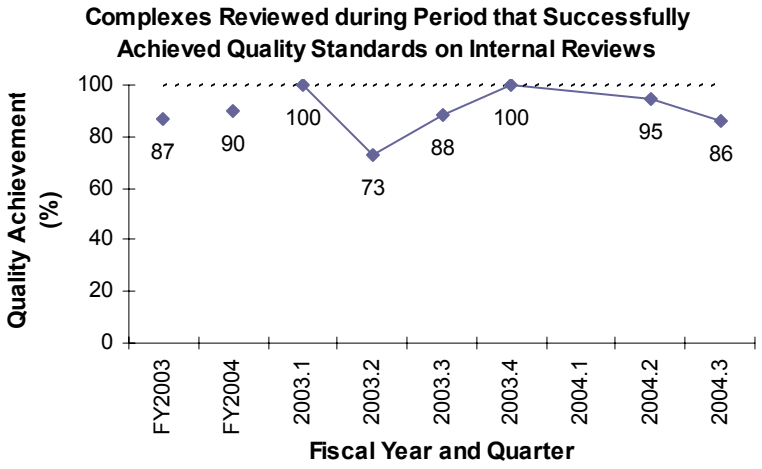


Any performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed by the FGC internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. The FGC management team tracks the implementation of each improvement strategy.

Goal:

⇨ 100% of complexes will maintain acceptable scoring on internal reviews*

Of the complexes reviewed in the third quarter, 86% met the performance goal. Twenty-two complexes were reviewed in the second quarter and three complexes, Waiakea, Kealakehe, and Waipahu, did not meet the goal. Acceptable scoring continues to be defined as achieving acceptable system performance for 85% of cases reviewed. The performance target is for 100% of complexes to meet the goal for acceptable system performance. In this school year, 90% of complexes statewide met this goal.



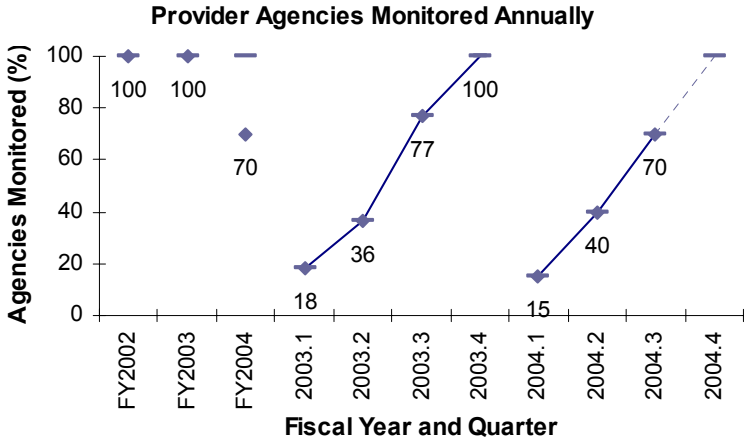
Waiakea and Kealakehe fell short of the goal, scoring 77% on system performance. For Waipahu Complex, the system performed acceptably well for 75% of youth. The complexes have developed improvement plans, which will closely monitored for implementation.

Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ 100% of provider agencies are monitored annually

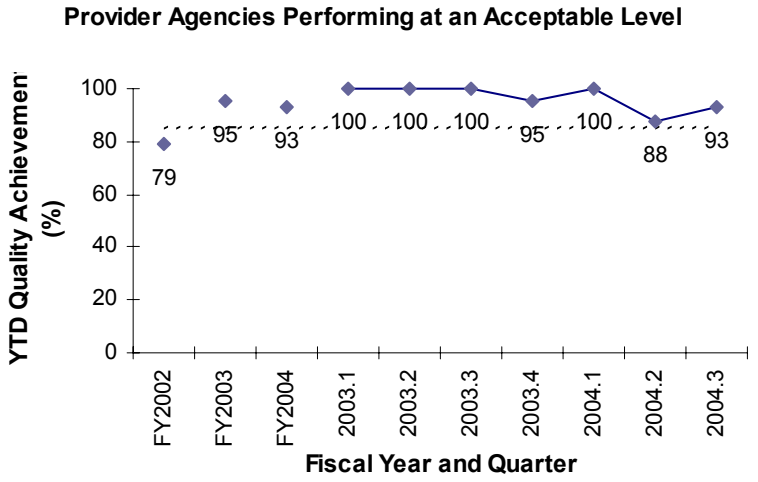
The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. Programmatic reviews, including case-based reviews, allow for a focused examination of safe and effective practices. In this quarter, 100% of all agencies contracted to provide direct mental health services were monitored as scheduled, which represents 70% of the annual goal. Six agencies, representing ten contracts and five levels of care, were monitored in the third quarter.



Goal:

⇨ 85% of provider agencies are rated as performing at an acceptable level

In the reporting quarter, 93% of the provider agencies reviewed were found to be performing at an acceptable level, meeting the goal for this measure. Provider agencies are reviewed across multiple dimensions of quality and effective practices. To date for the fiscal year, 93% of the agencies reviewed have been found to be performing at an acceptable level.

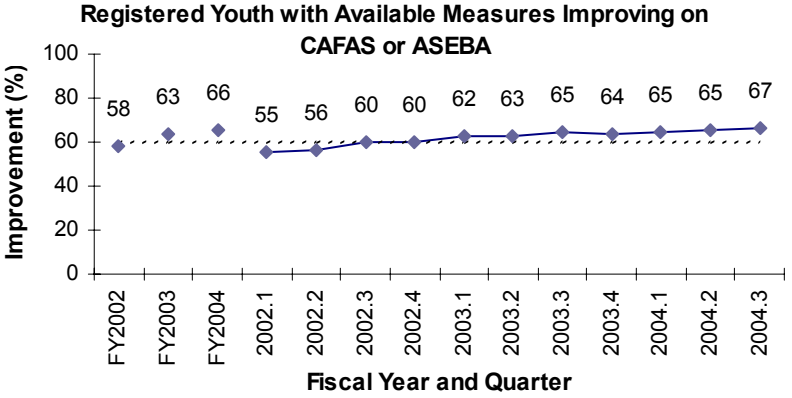


CAMHD will demonstrate improvements in child status

Goal:

⇨ 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA)*

To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to complete the CAFAS and Achenbach (ASEBA) for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%.

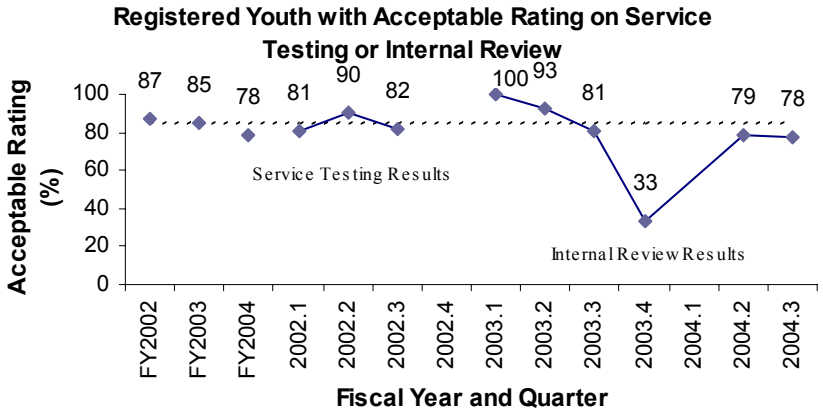


In the reporting quarter, for youth with data for these measures, 67% were showing improvements since entering the CAMHD system, which meets the performance goal. There has been a steady upward trend in functional improvements for youth served by CAMHD. Child functioning as measured by these scales has improved by 7% since the end of FY 2002.

Goal:

⇨ 85% of those with case-based reviews show acceptable child status

Of youth receiving care coordination and services through CAMHD, 78% were found to be doing well against measures of child well-being. This falls short of CAMHD's goal of 85% of youth doing well in child status, and marks the second consecutive quarter where child status was below the performance goal. Each child with unacceptable child status ratings are referred to their FGC clinical team for review of factors impacting well-being.



Families will be engaged as partners in the planning process

Goal:

⇨ 85% of families surveyed report satisfaction with CAMHD services

As discussed in last quarter's report, CAMHD has contracted with a professional, National Committee for Quality Assurance (NCQA) certified health research vendor. Several factors prompted this decision. Because CAMHD is a managed behavioral health plan for Medicaid-eligible youth with intensive mental health issues, it must adhere to Medicaid standards. Med-Quest Division is requiring administration of the Experience of Care and Health Outcomes (ECHO) survey on an annual basis for Quest- involved youth. CAMHD expects that the use of the ECHO survey with the NCQA protocol will provide higher quality, albeit less frequent information on family perceptions. Therefore, reporting on family satisfaction will move to annual reporting starting in July, 2004.

There will be state-level quality performance that ensures effective infrastructure to support the system

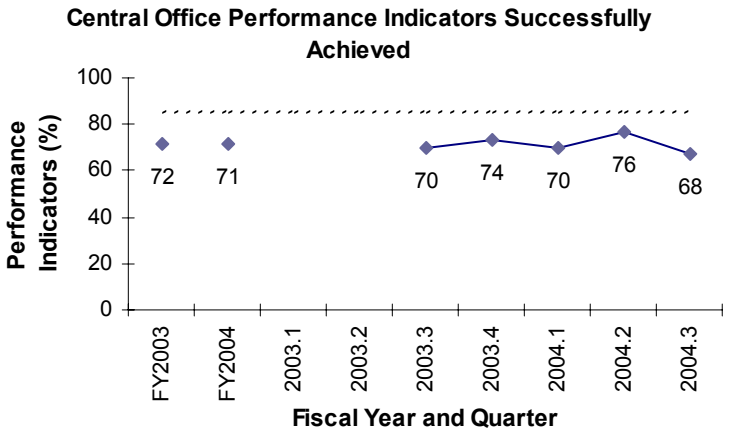
Goal:

⇨ 85% of CAMHD Central Office performance measures will be met.

CAMHD's Central Administrative Offices utilize performance measures for each section under the Clinical Services, Performance Management and Administrative Offices as an accountability and planning tool. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT), and are reported monthly or quarterly depending on the measure. Performance results and trends are discussed and strategies are developed to sustain or improve performance. There are a total of 37 measures currently tracked by EEMT. Over time, measures may be graduated, and new measures selected based on strategic initiatives and priorities of the organization.

In the third quarter, 68% of measures were successfully met, which does not meet the performance goal for this quality indicator. The measures that fell below expectations were generally impacted by staff vacancies within particular sections.

Improvements to impact Central Office performance measures are managed by respective sections of CAMHD. When solutions require a broader organizational intervention, these are discussed on the regular Expanded Executive Management Team level, and are tracked for implementation.



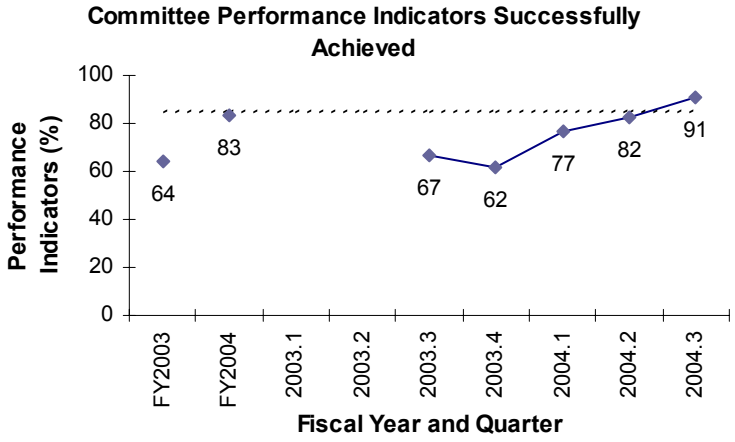
Goal:

⇨ 85% of CAMHD State Committees performance measures will be met.

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Credentialing, Safety and Risk Management, Grievance and Appeals, Utilization Management, Evidence-based Services, Compliance, Information Systems Design, and Training. A total of thirteen measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in the monthly PISC meetings in order to identify improvement strategies

that are implemented by respective CAMHD section managers.

In the quarter 91% of performance measures were met through the work of the CAMHD Committees, which meets the goal for this quality indicator and is the best performance in PISC measures to date. Focused improvement initiatives have had a major impact on improved performance.



Summary

The majority of performance goals were met or exceeded in the third quarter. The asterisked measures are those linked to historical Federal Court benchmarks. Of these "sustainability measures", all indicators fully met the performance goal in the reporting quarter except for filled care coordinator positions, which was 1% below targeted performance, and internal complex review scoring which was 29% below targeted performance. Several of the non-core measures were also below benchmark. The areas of strength are in the areas of funding, timely access to services, system responsiveness to stakeholder concerns, serving youth within the State, CAMHD Committee performance, timely and quality service plans, and quality service provision.

The following were measures that met or exceeded goals:

- Filled central office positions*
- Care coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Contracted providers paid within 30 days
- Youth receiving services within 30 days of request*
- Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns:*
  - Youth with no documented complaint received
  - Provider agencies with no documented complaint received
  - Provider agencies with no documented complaint about CAMHD performance
- Youth receiving treatment within the State of Hawaii*
- Coordinated Service Plan timeliness*
- Coordinated Service Plan quality*
- Monitoring of provider agencies
- Quality service provision by provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA*
- State Committees performance indicators

The following measures demonstrated a stable or improving trend, but did not achieve the targeted goal:

- Filled Care Coordinator positions*
- Youth receiving treatment while living in their homes
- Central Office performance indicators

The following measures were below targeted performance with observed decreases, and will require implementation of improvement strategies as discussed in the body of this report:

- Child Status as measured by Internal Review Results
- Family Guidance Center performance indicators
- Complexes reviewed during the period that maintained acceptable scoring on Internal Review*

Family Satisfaction data, as discussed in this report, will be reported on at the end of the fiscal year following receipt of data from external evaluation by the OmniTrak Group, Inc.

For each measure below its targeted goal, a full analysis of factors affecting performance is routinely conducted, and recommendations for improvement are implemented through PISC and the CAMHD management team.

The reporting period experienced a continued trend in demonstrating stable services and service-delivery infrastructure. Most of the measures of sustainability were either met, or represent a stable and improving trend. The one exception was the percentages of Complexes reviewed that maintained acceptable scoring on Internal Reviews. In the quarter, 86% and in the year 90% of Complexes achieved the performance goal. This trend will be carefully monitored, and will be a focus of review by the State-Level Interagency Quality Assurance Committee at its summer retreat. Examination of these data provides an excellent opportunity to assess the factors impacting each Complex, and activate any needed State-level supports.

CAMHD has made substantial strides in not only its ability to measure and report on core areas of its quality strategy, but on the overall development of a family-centered system of care. In partnership with families, communities and other child-serving agencies, CAMHD has built performance management and results-focused practices that are able to continuously address the complexities of refining and advancing the children's mental health system in Hawaii. Focus on measurement, reporting and accountability for making improvements continue to be core CAMHD functions. Recently, CAMHD conducted an interim evaluation of all its performance measures (of which those presented here are a subset), and progress made over the year on each of those measures. Over the next several months, this evaluation will inform further refinements in measurement and reporting.